

# A New Look at Nonprofits: Health Care Policy in a Competitive Age

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The importance of organizational form in American medicine has been the subject of much debate. But the character of the debate—the nonprofit form versus its competitors—has been sufficiently confused that much of the controversy should be reconsidered. That debate has been both ideological (commercialism and profit versus service and professionalism) and practical (which form is more efficient)? The challenge of public policy is to adapt public rules to the central realities of American medicine, not the shibboleths of shrill discourse. In the case of medicine, factors other than the form of legal ownership—among them, the nature of the service provided, the developmental stage of the service, the role of physicians in providing the service, and the nature of government regulation—are more important in fashioning those appropriate responses.

The radical transformation that has been occurring in American medicine is not substantially explained by changes in organizational form. What we are witnessing is a shift in the character of American medicine—a rise of commercialism and a decline of a professional ethos—that cuts across organizational forms. Ownership-based policies alone cannot reverse this trend. A restoration of the fundamental values of caring, historically associated with charitable nonprofit institutions but endangered by growth and depersonalization of the medical industry, is

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essential. So, paradoxically, the central conclusion of a discussion of non-profits in medicine is that the environment facing decision makers in medical institutions and the conventions by which they operate are more significant than what institutions call themselves on their legal charters.

This article aims to provide a more accurate and better balanced assessment of the role of nonprofit organizations in health care. Part I introduces the debate over the effect of various organizational forms in health care and criticizes the failure of commentators to examine the systematic effects of organizational form on cost, quality, and accessibility of American medical care. Part II examines the history of the nonprofit form in American medicine and attempts to set that story in the broader history of American medical care. Part III surveys empirical studies of the effects of organizational form on health care cost, quality, and access. In Part IV we address the policy implications of both the historical and contemporary differences between for-profit and nonprofit organizations in health care and present our recommendations for sensible policy responses. We conclude that flexible policies based on organizational form should be used to exploit the limited but systematic differences between for-profit and nonprofit institutions, though we emphasize that the major problems facing health care today cannot be alleviated by ownership-based policies alone.

## I. The Debate over Organizational Forms in Health Care: The Triumph of Rhetoric over Reality

The proper role of nonprofits in the health care industry and the appropriate public policy toward nonprofit health care providers are subjects mired in controversy. The history of this organizational form in medicine—and the comparison of nonprofit with governmental and for-profit health institutions<sup>1</sup>—is itself contentious, and the appraisal of

1. The for-profit health care provider usually takes on the familiar corporate form. In particular, the company is owned by its stockholders and managed by a board of directors elected by the stockholders. Capital is raised through the sale of equity and the issuance of debt. Any net earnings are distributed in the form of dividends to the stockholders or retained and reinvested by the corporation, rendering the stock more valuable. See W. CARY & M. EISENBERG, *CASES AND MATERIALS ON CORPORATIONS* (5th ed. 1980).

The nonprofit corporation, in comparison, does not issue equity. A nonprofit may accrue net earnings, but no dividends are paid. Any net earnings must be retained by the corporation. (A commercial nonprofit organization must make a profit to survive, especially in medical care. The distinction between nonprofit and for-profit enterprise rests largely on what is termed the nondistribution constraint, that is, profits cannot be distributed to individuals. Hansmann, *Economic Theories of Nonprofit Organization* in *THE NONPROFIT SECTOR: A RESEARCH HANDBOOK* (W. Powell ed. forthcoming) [hereinafter cited as Hansmann, *Economic Theories of Nonprofit Organization*]. The corporation is managed most often by a board of directors, either elected by the membership (which can include either donors or beneficiaries) or self-perpetuating. Thus, unlike the for-profit corporation, there is no formal connection between an individual's financial interest in the venture and the power to select and control management. See Hansmann, *Reforming Nonprofit Corporation Law*, 129

contemporary arrangements is marked by fundamental differences of value, perspective, and fact.

### A. *The Controversy Portrayed: Nonprofits vs. For-Profits*

The history of nonprofits in American medicine is quite variously portrayed. For hospitals, the nonprofit form is undoubtedly the dominant legal organization today. For some interpreters, the history is one of evident triumph over the profit-making small hospital. For others, however, the story describes either an endangered species reeling under the competition of large hospital chains, or a changing balance among forms of hospitals in which the dominant theme is convergence, not differentiation. As with hospitals, so with physicians. They are alternately regarded as profit-making entrepreneurs cloaked in the misleading rhetoric of service professionalism or technically expert professionals resisting the commercial blandishments of corporate medicine.<sup>2</sup> These conflicting perspectives shape the character, tone, and policy conclusions of much recent scholarship about the history of American medicine.<sup>3</sup> Historical controversy spills over into disputes about what is currently taking place in American medicine. Change is everywhere reported,<sup>4</sup> but its dimensions,

U. PA. L. REV. 497 (1981).

Some, but not all, nonprofit corporations are charities under Section 501(c)(3) of the federal tax law. I.R.C. §501(c)(3) (1985). The charity status is important because donations to charitable organizations are tax deductible to the donor, thus conferring a significant federal subsidy upon nonprofit charities that receive contributions. State and federal tax laws also define a category of nonprofits that are exempt from corporate income, sales, and other taxes. See Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54 (1981).

Professor Hansmann describes differences among nonprofits based upon two characteristics: the source of income and the form of management or control. The "donative nonprofit" relies primarily on donation income, while the "commercial nonprofit" derives its income primarily from the sale of goods or services to paying consumers. The "mutual nonprofit" is run by a board selected by the donors or consumer members, while the "entrepreneurial nonprofit" is managed by a self-selected board. The dominant form of nonprofit in the health care industry is the entrepreneurial/commercial nonprofit. Nonprofit hospitals, although they qualify as charities, receive the great bulk of their income from sale of services. This is particularly true of nursing homes, which are rarely the recipients of charitable donations of any significant size. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 838-43 (1980).

The third set of actors in health care are the public providers. Cities, counties, states, and the federal government all operate hospital and health facilities of various kinds. The capital funds are tax dollars, and the management is under the formal control of the sponsoring government.

2. See, e.g., Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 964, 967-68 (1980); Yordy, *Current and Future Developments in Health Care*, 62 BULL. N.Y. ACAD. MED. 27, 32 (1986).

3. See, e.g., *THE NEW HEALTH CARE FOR PROFIT* (B. Gray ed. 1983); P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982); R. EVANS, *STRAINED MERCY: THE ECONOMICS OF CANADIAN HEALTH CARE* (1984).

4. See Goldsmith, *Death of a Paradigm: The Challenge of Competition*, 3 HEALTH AFF. 5 (1984); Gray, *An Introduction to the New Health Care for Profit* in *THE NEW HEALTH CARE FOR PROFIT* 1 (B. Gray ed. 1983) [hereinafter cited as Gray, *Introduction*]; Gray, *Overview: Origins and Trends*, 61 BULL. N.Y. ACAD. MED. 7 (1985) [hereinafter cited as Gray, *Overview*].

consequences, and meanings are bewildering. Although the proportion of proprietary hospitals among all hospitals has not increased, within the for-profit hospital sector the number of hospitals organized in investor-owned chains has doubled between 1973 and 1982,<sup>5</sup> and for-profit firms now own and manage hospitals that used to be publicly run, controlled by nonprofit boards, or the preserve of physician owners.<sup>6</sup> Some nonprofit hospitals imitate the new corporate form by forming themselves into large systems.<sup>7</sup> Furthermore, the merging of substantial health-related institutions is not restricted to hospitals. Symptomatic of the vertical integration taking place in health was the proposed 1985 merger of the for-profit Hospital Corporation of America (HCA) with American Hospital Supply (AHS), a multi-billion dollar fusion of health giants (the largest in their respective sectors) that dominated front pages of the nation's newspapers for a few days in March, 1985.<sup>8</sup>

To complicate matters further, nonprofit hospitals themselves have increasingly taken to the corporate marketplace, spawning for-profit subsidiaries, seeking debt financing that differs from stocks and bonds in legal name only, and searching for ways to imitate insurance companies, consulting firms, and industrial park entrepreneurs.<sup>9</sup> Health maintenance organizations (HMOs), home health agencies, dialysis and urgent care centers, and other extra-hospital forms are increasingly managed under proprietary auspices. All of this takes place in the full view of the national media, delighted to repeat the passionate exchanges of defenders of various faiths—markets, governments, and nonprofits.<sup>10</sup> No wonder, then,

5. Gray, *Overview*, *supra* note 4, at 12.

6. *Id.*, at 10-11; Gray, *Introduction*, *supra* note 4, at 2-3.

7. As of 1982, there were 34 investor-owned multi-hospital systems comprising 773 hospitals and 139 nonprofit systems comprising 967 hospitals (up from 121 nonprofit systems in 1978). Gray, *Overview*, *supra* note 4, at 13. This source offers a current review of the growth of nonprofit and proprietary hospital systems and recent activity in institutions other than hospitals.

8. In the event, Baxter Travenol won the battle for AHS, outbidding HCA to produce a huge, four billion dollar, horizontal conglomerate. Had HCA succeeded, the result would have been the largest U.S. health care firm—a vertically integrated conglomerate with an estimated \$7.6 billion in annual revenues. Waldholz, *American Hospital Plans to Merge with Hospital Corp. in Stock Swap*, Wall St. J., Apr. 1, 1985, at 3, col. 1; Koten & Waldholz, *Baxter Travenol Bids \$3.6 Billion for Supply Firm*, Wall St. J., June 24, 1985, at 2, col. 2; Koten, *Baxter to Buy American Hospital Supply*, Wall St. J., July 16, 1985, at 2, col. 2.

9. See Gray, *Overview*, *supra* note 4, at 17-19. This diversification and imitation of for-profit providers is a major trend among big city voluntary hospitals. Its extent is evident from the incorporation of Voluntary Hospitals of America, recently formed by 62 voluntary hospitals. Its subsidiary activities, all of which are for-profit, extend to management services, physician recruitment, outpatient services, supply services, financing and insurance. *Id.* at 18. See also VOLUNTARY HOSPITALS OF AMERICA, 1984 ANNUAL REPORT.

10. One example is the active debate in recent years in the *New England Journal of Medicine* over the seamliness of proprietary agencies treating end-stage renal disease. See, Lowrie & Hampers, *The Success of Medicare's End-Stage Renal Disease Program*, 305 NEW ENG. J. MED. 434 (1981) ("The Case for Profits and the Private Marketplace"); Relman & Rennie, *Treatment of End-Stage Renal Disease: Free But Not Equal*, 303 NEW ENG. J. MED. 996 (1980) (examination of

that rational appraisal of where we are and where we are going is difficult.

Questions are often raised as to whether nonprofits behave inefficiently or whether they provide useful services that profit-making competitors shun. Other questions ask whether doctors are compromised by working in hospitals controlled by corporations seeking profit. The debate is often cast as a battle over how to rationalize an industry that grew fat, sloppy, and uncontrollable in an era of increased subsidies for medical care, medical research, and medical tinkering. Few analyses of health care services manage to emerge without being cast in the language of good and evil, delight and doom, prudence and waste. The nonprofit form is lauded or derided, seen as inherently inefficient or a benevolent community institution, regarded as threatened or about to recover.<sup>11</sup> The growth of for-profit chains prompts journalistic categorization, and new monikers produce an acronymic frenzy—AMI, HCA, VHA.<sup>12</sup> Arnold Relman's "New Medical Industrial Complex" (NMIC), modeled on President Eisenhower's dreaded military industrial complex of the 1950's,<sup>13</sup> is but the most striking example. In a four hundred billion dollar industry, there is more than enough money to finance companies of public relations specialists and lobbyists, all of whom can be relied on to produce dear or dread emblems of a benevolent or beastly past, a wondrous or dangerous present, and a hopeful or fearful future.<sup>14</sup>

the variation in levels of dialysis treatment both nationally and internationally); Gardner, *Profit and the End-Stage Renal Disease Program*, 305 NEW ENG. J. MED. 461 (1981) (asking why more "for-profit" dialysis facilities are associated with relatively fewer patients receiving transplants and undergoing dialysis at home).

11. For a critical assessment of nonprofit hospitals, see Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980); Clarkson, *Some Implications of Property Rights in Hospital Management*, 15 J. L. & ECON. 363 (1972).

12. American Medical International; Hospital Corporation of America; Voluntary Hospitals of America.

13. Relman, *supra* note 2, at 963.

14. The clash of views is really quite stark. Criticizing the role of nonprofits, Clark states: Nonprofit hospitals may be operationally inefficient compared to their for-profit counterparts. Moreover, the nonprofit form may have played a key role in leading to both wasteful overcapacity of medical facilities in some areas and slow response to demand in others, while promoting the development of extremely costly and not truly justified 'high technology' medical care.

Clark, *supra* note 11, at 1417-18.

Criticizing to the growth of proprietary organizations in health, Relman states:

[T]he private health-care industry can be expected to ignore relatively inefficient and unprofitable services, regardless of medical or social need. The result is likely to exacerbate present problems with excessive fragmentation of care, overspecialism, and overemphasis on expensive technology.

Relman, *supra* note 2, at 969. See also Relman, *Investor-Owned Hospitals and Health-Care Costs*, 309 NEW ENG. J. MED. 370, 372 (1983) ("Judged not as businesses but as hospitals, which are supposed to serve the public interest, they [investor owned chain hospitals] have been less cost-effective than their not-for-profit counterparts.").

### B. *Refocusing the Debate*

The debate over the proper ownership of health institutions has been complicated by an unfortunate tendency to equate profit-making with market-based allocations of services, to equate the proprietary form with profit-making, and to cast ownership-related issues as crucial to the future evolution of American medicine. There may be strong reasons to favor more or less reliance on markets in allocating some health services, but these can be separated in principle and practice from analyses of the appropriate role of for-profit or nonprofit health care.<sup>15</sup> Changes in the ownership mix of health care providers may well have some important implications for health policy, but completely eliminating either for-profit or nonprofit providers would remedy few, if any, of the problems facing health policy-makers.

The relationship between provider and consumer of medical services differs in several important ways from that for other services. The asymmetry of information between the provider and the patient is more pronounced than for most services, even compared to areas in which nonprofit ownership is common.<sup>16</sup> The importance of these asymmetries is heightened by the complex emotions associated with the trauma of injury and dread disease. For many, it is crucial that the relationship between provider and patient be one of "care-giving" for in no other service except perhaps prostitution is the pursuit of profit alone considered to be so antithetical to the personalized relationship that is seen as most desirable. Consideration of this asymmetry of information—and the accompanying trust patients must place in providers—has, in the past, shaped the policies that constrain the practices of health professionals.<sup>17</sup> The medical professions have gained unusual authority in the belief that professional norms and sanctions would appropriately limit medical behavior.<sup>18</sup> There have been extensive attempts to encourage the ethic of care-giving through

15. See A. ENTHOVEN, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* 70-92 (1980) (advocating increased reliance on competitive market forces as the answer to rising health care costs); Dunham, Morone & White, *Restoring Medical Markets: Implications for the Poor*, 7 J. HEALTH POL. POL'Y & L. 488 (1982) (suggesting that current proposals for increased competition would only partially solve inflation problem while significantly reducing health services for the poor).

16. Steinberg, *Nonprofit Organizations and The Market* in *THE NONPROFIT SECTOR: A RESEARCH HANDBOOK* (W. Powell ed. forthcoming).

17. The nonprofit has traditionally been the protector of consumers or purchasers of services from "contract failure." By virtue of its distribution prohibition, the nonprofit protects the buyer against the misdelivery of services he cannot monitor or understand. Hansmann, *Economic Theories of Nonprofit Organization*, *supra* note 1. Given that, in the case of health care, this protective function was vested in the doctor as the patient's agent, this traditional role of the nonprofit was less important than in other spheres.

18. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 951-53 (1963).

education, honorific example, and nonmonetary rewards.<sup>19</sup> The judgment that professional norms are insufficient to regulate the medical industry has led to extensive legislation to limit costs, maintain quality, and broaden access to medical care.<sup>20</sup> Many of these policies have been explicitly designed to promote nonprofit organizations, either by enforcing less stringent regulations on them or providing subsidies not available to their for-profit counterparts. "Numerous statutes, regulations, and judicial doctrines," we are reminded, "discriminate against for-profit hospitals"<sup>21</sup> including preferential access to construction grants, subsidies for training programs, and planning and operational assistance for a range of health services.<sup>22</sup>

The current debate has confused the fundamental concerns over cost, quality, and access with issues of ownership. Casting the argument in terms of a choice between legal forms in health care obscures the historical sources of the present situation. What we are witnessing is a heightening of an older fundamental tension within medicine over whose interests should predominate. The steady pressure of rising costs, combined with the opportunities to earn high returns in medical care, have caused this tension to resurface.

Designing policies to meet the current situation is made more difficult by the complexity of medicine and, as shown in Table 1, the diversity of institutions providing services. Nonprofit organizations treat acute illness,<sup>23</sup> palliate chronic conditions,<sup>24</sup> and provide supportive services such

19. The importance of nonmonetary incentives in health care has led Robert G. Evans to define the "not-only-for-profit" sector. This designation refers to individuals and firms "in which a legal claimant to profits is well-defined, but profits represent only one among several competing objectives of the firm's ownership and management." R. EVANS, *supra* note 3, at 127.

20. The resulting regulation rejected the view that the organization of medical care should be the province solely of doctors and hospitals. P. STARR, *supra* note 3, at 402; Brown, *The Proper Boundaries of the Role of Government*, 62 BULL. N.Y. ACAD. MED. 15, 22-23 (1986). Thus, the perspective of health professionals was counterbalanced by that of consumers who were required to compose a majority of the membership of state health planning councils, Comprehensive Health Planning and Public Health Services Amendments of 1966, § 314(a)(2)(b), 42 U.S.C. § 246(a)(2)(b) (1982), and health systems agencies (HSAs), The National Health Planning and Resources Development Act of 1974, § 1512, 42 U.S.C. § 300l(1)(b)(3)(C)(i) (1982).

Among the chief concerns of the statute were the maldistribution of health care services and inadequate access available to the disadvantaged. The National Health Planning and Resources Development Act of 1974, § 1502(1), 42 U.S.C. § 300k-2(a)(1) (1982). See also M. RAFFEL, *THE U.S. HEALTH SYSTEM: ORIGINS AND FUNCTIONS* 601-02 (1980).

Examples of the effort to control the cost and quality of the services that all patients receive are The Social Security Amendments of 1972, § 249F, 42 U.S.C. §§ 1320c-1320c-19 (1982), and The National Health Planning and Resources Development Act of 1974, § 1513(a), 42 U.S.C. §§ 300l-2(a) (1982). See also M. RAFFEL, *supra*, at 601-02.

For additional detail on legislative efforts to control cost, quality, and access, see *infra* note 77.

21. Clark, *supra* note 11, at 1473.

22. *Id.* at 1473-75. Ownership based incentives, however, have often been unnecessary or even counterproductive to primary policy goals. See *infra* Part IV (A).

23. Examples of nonprofit organizations which treat acute illness include hospitals, health

**TABLE 1**  
**Share of For-Profit, Private Nonprofit, and Public**  
**Providers in Health Care Markets**

Services (Year)	Measured In Terms Of	Percent of Services Provided By		
		For-Profit	Nonprofit	Public
Short-Term General Hospitals (1980)	Beds	8.8%	69.9%	21.3%
Psychiatric Hospitals (1981)	Beds	6.0	4.7	89.3
Nursing Homes (1976)	Beds	68.8	20.0	11.2
Homes for Mentally Handicapped (1976)	Residents	46.2	37.7	16.5
Blood Banks (1976)	Facilities	63.3	5.8	30.9
Dialysis Centers (1981)	Dialysis Units	33.0	51.3	15.7
Health Insurance (1978)	Enrollees	43.4	46.1	10.6
Home Health Agencies (1983)	Visits	25.5	64.1	10.4

Source: M. Schlesinger, *Public, For-Profit and Private Nonprofit Enterprises: A Study of Mixed Industries 6-8, 76-80* (1984) (unpublished doctoral dissertation, University of Wisconsin at Madison).

as insurance,<sup>25</sup> education and lobbying,<sup>26</sup> and research.<sup>27</sup> Because the institutional missions and the roles of professionals vary greatly across health services, it is not surprising, as will be shown below, that the implications of ownership vary as well.

## II. The Lessons of History: An Examination of the Role of Nonprofits in the Provision of Medical Services

The relative importance of nonprofit and for-profit health institutions has fluctuated over time. Services that are now dominated by nonprofit institutions, such as acute care hospitals, were at one time predominantly

maintenance organizations, and neighborhood health centers.

24. Examples of institutions which palliate chronic conditions include home health agencies, nursing homes, and renal dialysis centers.

25. Blue Cross and Blue Shield are the foremost examples of such organizations.

26. The American Medical Association and the American Hospital Association supply examples of this education and lobbying function.

27. Nonprofit organizations which conduct research include, among many others, the March of Dimes and the American Cancer Society.



investor-owned. Services that now have a substantial proprietary component, such as health maintenance organizations (HMOs) and renal dialysis facilities, were only fifteen years ago almost exclusively provided by private nonprofit and public agencies.<sup>28</sup> These variations in patterns of ownership suggest that diverse and interrelated factors determine the scale and role of nonprofit enterprise in medical care. Three distinct historical periods of change in the mix of ownership form throughout the medical care industry emerge from our investigations.

### A. *1900-1950: The Institutionalization of Health Care and the Dominance of Nonprofit Organizations*

Throughout most of the nineteenth century, medical care was largely a "cottage industry." Hospitals were principally facilities for caring for the sickly poor. Those with higher incomes were treated at home by physicians. Hospitals and physicians co-existed, the former supported by religious organizations and government subsidies, the latter by fees from patients.<sup>29</sup> Because of their religious affiliations, most hospitals established during this period were nonprofit. Toward the end of the nineteenth century, however, the practice of medicine became more complex and physicians began treating more of their patients in hospitals. Hospitals evolved into the primary setting for treating the very ill and began to require patient fees for support.<sup>30</sup> In this evolution, for-profit and nonprofit hospitals retained many of the distinctions which had previously existed between doctors and hospitals. The for-profit facilities generally continued to be operated by a single doctor or small group of physicians and catered to wealthier patients.<sup>31</sup> The usually larger nonprofit hospitals continued to rely heavily on philanthropic support, although cost increases eventually created pressure for more sophisticated management techniques and some patient payment.<sup>32</sup>

28. M. Schlesinger, *Public, For-Profit and Private Nonprofit Enterprises: A Study of Mixed Industries* 80 (1984) (unpublished doctoral dissertation, University of Wisconsin at Madison).

29. On the progress of hospitals in the nineteenth century, see M. RAFFEL, *supra* note 20, at 241-46; P. STARR, *supra* note 3, at 145-79; Stevens, "A Poor Sort of Memory": *Voluntary Hospitals and Government before the Depression*, 60 MILBANK MEMORIAL FUND Q. 551, 552-55 (1982).

30. P. STARR, *supra* note 3, at 157, 160-61.

31. *Id.* at 165.

32. *Id.* at 160-61. The absence or presence of philanthropy led to pronounced regional variations in ownership mix. The East and Midwest, populated by service-oriented religions and philanthropically minded capitalists, were dominated by nonprofit hospitals. The West, however, lacked a strong philanthropic tradition, having been settled after hospitals had begun to rely more heavily on patient fees for support and after the charitable mission of care for the poor was no longer the hospital's sole function. Here, for-profit hospitals were far more common. *Id.*, at 170-71.

As the country grew to the West during the late nineteenth century, proprietary hospitals and medical schools proliferated.<sup>33</sup> At the same time the growth of nonprofit facilities was further inhibited because the newly developed facilities in the West relied less upon government subsidies and more heavily upon income from private patients.<sup>34</sup> By 1900, sixty percent of the hospitals in operation were privately owned, usually by one doctor.<sup>35</sup>

The subsequent fifty years brought increased formalization, standardization, and institutionalization to American medicine. Medical schools, hospitals, and, to a lesser extent, nursing homes, became more uniform and more technically-oriented. The increasing complexity of medical care raised the cost of both medical training and treatment, creating a greater need for funds in the form of either increased government financing or larger payments from patients.<sup>36</sup> This financial pressure in turn favored the growth of new nonprofit institutions which could tap religious affiliations,<sup>37</sup> offer income tax deductions,<sup>38</sup> and remain informally exempt from growing government regulation.<sup>39</sup>

Economic incentives and professional interests combined to make the nonprofit form more strongly favored by a large proportion of the medical profession. The increased emphasis on the technical aspects of medicine and the institutions' dependence on fee-paying patients allowed doctors to become the dominant decision-makers in hospitals.<sup>40</sup> Rejecting for-profit enterprise reduced the threat of corporate control over physician authority.<sup>41</sup> Since antitrust laws were only loosely applied to nonprofit institutions, the nonprofit also provided a way to control entry into medicine and to enhance the financial returns of a medical practice.<sup>42</sup>

33. For a discussion of the increased number of proprietary hospitals, see *id.* at 165. The rise of proprietary medical schools is described in R. STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* 24-25 (1971).

34. Stevens, *supra* note 33, at 560. See also P. STARR, *supra* note 3, at 160 (discussing the 1904 New York City hospital finance crisis in which private hospitals found government had its own cost problems and money was not readily available).

35. Bays, *Why Most Private Hospitals are Nonprofit*, 2 J. POL'Y ANALYSIS & MGMT. 367 (1983). There was not yet a technological justification for big institutions, and in most cases the small proprietary hospital/clinic corresponded well to the then-dominant solo practice.

36. P. STARR, *supra* note 3, at 159-61.

37. The importance of religious organizations in the development of hospitals is detailed in P. STARR, *supra* note 3, at 169-77. Their role in establishing nursing homes is discussed in B. VLADECK, *UNLOVING CARE: THE NURSING HOME TRAGEDY* 35 (1980).

38. See I.R.C. §§ 170(a), 170(c), 501(c)(3) (1985).

39. W. NIELSEN, *THE ENDANGERED SECTOR* 184 (1979).

40. P. STARR, *supra* note 3, at 161. But see W. NIELSEN, *supra* note 39, at 178 (discussing the split between "two lines of authority"—the clinical and the administrative—which developed in the 1930's and 1940's).

41. P. STARR, *supra* note 3, at 215-220.

42. See Harty & Mulholland, *Legal Differences Between Investor-Owned and Nonprofit Health Care Institutions*, in *THE NEW HEALTH CARE FOR PROFIT* 17 (B. Gray ed. 1983).

The trend toward the nonprofit form was reinforced, in the short run, by the introduction of health insurance during the early 1930's.<sup>43</sup> Faced both with proposals for national health insurance and with financially strained hospitals, the American Medical Association abandoned its earlier rigid opposition to hospital insurance.<sup>44</sup> With the cooperation of the American Hospital Association and enabling legislation passed by state governments,<sup>45</sup> Blue Cross and later Blue Shield ("the Blues") were established to offer hospital and medical insurance, respectively.

These provider-sponsored plans were organized as nonprofit enterprises for several reasons. Physician autonomy was, as noted before, promoted by the nonprofit corporate form.<sup>46</sup> In addition, the insurance companies worked closely with providers. Proprietary ownership of these health insurance companies might well have raised questions about the appropriateness of the nonprofit status of hospitals.<sup>47</sup> Finally, state enabling

One view suggests that American medicine became more mercenary in 1920 with a change in the control of American medicine. The purpose of the new group of leaders was to improve their economic position and to protect their freedom from social or governmental controls. Nielsen asserts that because the individual states worked closely with and patterned their licensing statutes on those suggested by the American Medical Association (AMA) and state medical societies, the AMA was largely responsible for the one-third decline in the number of proprietary medical schools and the one-half decrease in the number of medical graduates. W. NIELSEN, *supra* note 39, at 106. *See also* Bays, *supra* note 35, at 367 (providing figures on the relative numbers of for-profit and nonprofit hospitals). The remaining for-profit institutions were disproportionately located in fast growing areas, where population increased faster than philanthropic voluntarism supplied new capital or where the philanthropic tradition was weak. Steinwald & Neuhauser, *The Role of the Proprietary Hospital*, 35 LAW & CONTEMP. PROBS. 817, 819-20 (1970). *See generally* Weller, *The Primacy of Standard Antitrust Analysis in Health Care*, 14 U. TOL. L. REV. 609, 613-15 (1983) (an historical review of antitrust enforcement of health care).

43. The origin of Blue Cross is traced to 1929 when Dr. Justin Ford Kimball established a hospital insurance plan at Baylor University Hospital. *See* M. RAFFEL, *supra* note 20, at 393-94 (1980); P. STARR, *supra* note 3, at 295-98. Thirty-nine Blue Cross plans were established in the early 1930's. S. LAW, BLUE CROSS: WHAT WENT WRONG? 6-7 (1974). State and federal financing of medical services for the poor was also instituted on a limited basis through New Deal legislation. *See* P. STARR, *supra* note 3, at 270-75; R. STEVENS & R. STEVENS, WELFARE MEDICINE IN AMERICA 13-14 (1974).

44. W. NIELSEN, *supra* note 39, at 112.

45. *See generally* Rorem, *Enabling Legislation for Non-Profit Hospital Service Plans*, 6 LAW & CONTEMP. PROBS. 528 (1939) (a study of hospital service plans and enabling acts including an appendix containing a "Proposed Model Law to Enable the Formation of Non-Profit Hospital Service Associations Under the Supervision of the Various State Departments of Insurance"); S. LAW, *supra* note 43, at 8-11 (review of the early history of hospital service plans); P. STARR, *supra* note 3, at 295-98 (brief history of "The Birth of the Blues"). As of 1978, 48 states had enabling legislation for such hospital service organizations. S. LAW, *supra* note 43, at 9 n.36.

46. For a review of AMA resistance to various other forms of health insurance, as well as to the "corporate" practice of medicine, *see* W. NIELSEN, *supra* note 39, at 105-16; P. STARR, *supra* note 3, at 299-306. The AMA's resistance to group health practice eventually resulted in its conviction for violating the Sherman Antitrust Act, 15 U.S.C. § 3 (1982). *American Medical Ass'n v. United States*, 317 U.S. 519 (1943).

47. In *Associated Hosp. Serv. Inc. v. City of Milwaukee*, 13 Wis. 2d. 447, 109 N.W.2d 271 (1961), for example, the court concluded that the legislature had the right to grant nonprofit status to the Blue Cross plan specifically because it was closely associated with nonprofit hospitals. 109 N.W.2d at 282-83. The American Hospital Association owned the name "Blue Cross of America"

legislation granted to the Blues what were effectively state-sanctioned monopolies in providing "service-benefit" plans.<sup>48</sup> Legislators, no doubt, favored nonprofit ownership in part to avoid the appearance of having sanctioned organizations which could extract monopoly profits from the health industry.<sup>49</sup>

The appropriate legal status of these health insurance plans was a matter of considerable dispute.<sup>50</sup> To bolster their claim to nonprofit status, the Blues adopted the policy of community rating, charging all residents of a community the same premium. This effectively subsidized the old and the poor who could afford to purchase insurance but who still had higher than average medical expenses.<sup>51</sup>

The growth of Blue Cross and Blue Shield reinforced the dominant position of nonprofit organizations in medicine. By the early 1940's, nonprofit plans controlled more than two-thirds of the health insurance market.<sup>52</sup> Blue Cross negotiated lower reimbursement rates for proprietary hospitals than for their nonprofit counterparts. This discrimination accelerated the decline of investor-owned facilities which by 1946 represented less than ten percent of all hospitals.<sup>53</sup> Physicians remained uncontested in their authority to control both the delivery and financing of medical care, authority mediated first by the nonprofit hospitals and later by Blue Cross. Nevertheless, the growth of insurance under the auspices of the

until 1972.

48. See S. LAW, *supra* note 43, at 8-9.

49. As Sylvia Law has written, "[H]istorically, the combination of public enabling legislation and the private power of the [American Hospital Association] has assured that there is only one Blue Cross organization in any given area and that it is, to some degree, controlled by the hospitals." *Id.* at 11.

50. About half the states refused to grant the plans tax exempt status. As of 1978 the twenty states which granted exempt status to the plans were Arizona, Arkansas, California, Connecticut, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Oklahoma, Vermont, West Virginia, and Wisconsin. *Id.* at 9 n.37.

According to Law:

Special corporate status and exemption from federal and state taxes seem to be based on a concept of social reform and utility rather than on any particular concrete characteristics of the Blue Cross plans. Neither the legislative history nor cases involving the validity of the tax exempt status provides much insight into the justification for the favored status of hospital service plans over commercial hospital insurers. State tax exemption has been challenged by tax collectors in five states. In all but one, the courts held that Blue Cross was not entitled to exemption from payment of state taxes, even though it had been characterized as charitable or benevolent by the legislature.

*Id.* at 9 (citations omitted).

Blue Cross plans are exempt from Federal income tax under I.R.C. § 501(c)(4) (1985). A § 501(c)(4) organization is exempt from federal income tax, but contributions to such an organization are not tax deductible by the contributor.

51. Coverage was rarely offered on a sliding scale or discounted in any other fashion for low-income subscribers. See P. STARR, *supra* note 3, at 309; S. LAW, *supra* note 43, at 12.

52. M. Schlesinger, *supra* note 28, at 79.

53. Steinwald & Neuhauser, *supra* note 42, at 817, 819.

Blues was to sow the seeds of the eventual rebirth of proprietary institutions in medicine.

## B. 1950-1975: Public Financing and the Renaissance of Proprietary Health Care

Following World War II, as federal policy-makers became increasingly concerned with encouraging access to medical care, legislation was passed subsidizing the medical industry.<sup>54</sup> At first, funds were paid directly to providers who agreed to care for the poor.<sup>55</sup> Later subsidies were directed at increasing the effective demand of patients for medical care. Unsuccessful attempts at national health insurance in the 1940's precipitated the drive in the 1950's for government health insurance covering the elderly. This led eventually to enactment of the Medicare program in 1965.<sup>56</sup>

Initially, the direct public financing of facilities tended to enhance the position of nonprofit institutions by making funds available either exclusively or preferentially to private nonprofit or public agencies. The post-war Hill-Burton program,<sup>57</sup> for example, subsidized construction of a variety of nonprofit and public health care facilities, though funds were primarily allocated to the construction of short-term general hospitals.<sup>58</sup> Because nonprofit agencies were relatively slow to respond to subsidies, however, their share of services increased only marginally despite the availability of these funds.<sup>59</sup> Moreover, by stimulating the expansion of public facilities, government subsidies indirectly altered, and to some extent undermined, the traditional role of private nonprofit medical care. Health institutions operated by state and local government grew rapidly during this period.<sup>60</sup> This growth, in turn, shifted much of the

54. See J. LAVE & L. LAVE, *THE HOSPITAL CONSTRUCTION ACT* (1974); Rosenblatt, *Health Care Reform*, 88 YALE L.J. 243, 264-270 (1978).

55. See, e.g., Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (current version at 42 U.S.C. §§ 291-291o) (1982 & Supp. V 1985) (establishing federal funding for construction and modernization of hospitals and other health care facilities).

56. See Social Security Amendments of 1965, Pub. L. No. 89-97 §§ 1801-1875, 79 Stat. 286 (1965) (current version at 42 U.S.C. §§ 1395-1395zz) (1982 & Supp. V 1985) (Medicare Act providing hospital and medical insurance for the aged, financed by federal payroll taxes); Social Security Amendments of 1965, Pub. L. No. 89-97 §§ 1901-1905, 79 Stat. 343 (1965) (current version at 42 U.S.C. § 1396-1396q) (1982 & Supp. V 1985) (Medicaid Act establishing federal matching funds for state medical assistance to the indigent). See also T. MARMOR, *THE POLITICS OF MEDICARE* 13-16 (1973).

57. 42 U.S.C. §§ 291-291o (1982).

58. Hill-Burton subsidized one-third of all hospital construction projects between 1947 and 1972, supplying about ten percent of the total capital costs. J. LAVE & L. LAVE, *supra* note 54, at 16.

59. *Id.* at 44-47; see also B. VLADECK, *supra* note 37, at 42 (discussing 1956 Social Security amendments which although significantly boosting available federal funds for nursing home care, were not widely taken advantage of by the states).

60. Between 1946 and 1960, the number of beds in short-term public hospitals increased from approximately 133,000 to 156,000. Between 1949 and 1959, the number of beds in public psychiatric

responsibility of caring for the poor to public institutions and away from their private nonprofit counterparts.<sup>61</sup> Coupled with the availability of public funds for capital projects, this shift reduced the apparent need for donative financing which had been one of the chief justifications for nonprofit status.

In the 1960's and continuing through the mid-1970's, government involvement expanded from subsidies for facilities to support for health insurance and direct payment for medical care. The passage of Medicare and Medicaid in 1965,<sup>62</sup> and amendments to Social Security in 1972<sup>63</sup> and 1974,<sup>64</sup> reflected this development. As Table 2 illustrates, this legislation had a significant impact on the mix of ownership in American medicine.

Rapidly growing health insurance—public and private—almost invariably led to a striking increase in the proportion of services provided by proprietary institutions.<sup>65</sup> The reasons for this growth are complex, but they probably reflect both organizational conflicts within nonprofit agencies and the ability of investor-owned organizations to acquire capital more readily.<sup>66</sup>

This pattern was first evident in the health insurance industry itself. Wage freezes during World War II and the Korean War prompted unions to push for increases in non-wage benefits. The most prominent growth took place in health insurance, with the number of enrollees growing sharply from less than thirteen million in 1940 to over 100 million in

hospitals increased from 596,000 to 672,000, and from 1954 to 1973, the number of beds in public nursing homes increased from 27,000 to 106,000. M. Schlesinger, *supra* note 28, at 76-77.

61. See Gage, *Impact on the Public Hospitals*, 61 BULL. N.Y. ACAD. MED. 75, 77 (1985); Feder, Hadley & Mullner, *Falling Through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982*, 62 MILBANK MEMORIAL FUND Q. 544 (1984).

62. See *supra* note 56. T. MARMOR, *supra* note 56, at 2 (summary of government involvement in medicine after 1945); R. STEVENS & R. STEVENS, *supra* note 43 (a history and survey of the Medicaid program); see also Brown, *Technocratic Corporatism and Administrative Reform in Medicare*, 10 J. HEALTH POL. POL'Y & L. 579 (1985) (examining administrative efforts to reform Medicare and the post-1977 federal activism which the author labels "technocratic corporatism")

63. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) (codified as amended in scattered sections of 42 U.S.C.).

64. Social Security Amendments of 1974, Pub. L. No. 93-368, 88 Stat. 420 (1974) (codified as amended in scattered sections of 42 U.S.C.).

65. See, e.g., B. VLADECK, *supra* note 37, at 105 (describing wave of nursing home construction in 1950's).

66. Policy analysts also suggest that proprietary hospitals tend to be smaller, and thus require less capital formation. See Steinwald & Neuhauser, *supra* note 42, at 828.

TABLE 2

## Market Share of For-Profit Health Care Providers Before and After Implementation of Public Subsidies

Type of Facility	Change in Coverage	Market Share of Proprietary Agencies	
		3-5 Years Before Change	3-5 Years After Change
Short-term General	Medicare Enacted 1965	5.8%	6.2%
Nursing Homes	Medicaid Enacted 1965	60	72
Dialysis Centers	Medicare Covered 1972	4	21
Home Health Agencies	Medicare Adds Coverage 1981	7	25
Psychiatric Hospitals	States Mandate Private Insurance Coverage 1975-80	1	6

Source: M. Schlesinger, *Public, For-Profit and Nonprofit Enterprises: A Study of Mixed Industries* 76-78, 80 (1984) (unpublished doctoral dissertation, University of Wisconsin at Madison).

1955.<sup>67</sup> With this growth in health insurance coverage, the market share of commercial insurers increased from thirty percent in 1940 to fifty-two percent in 1960.<sup>68</sup>

The growth of proprietary providers was even more pronounced after the enactment in 1965 of Medicare and Medicaid.<sup>69</sup> Initial implementation of these two programs boosted the relative share of services provided by investor-owned hospitals and nursing homes.<sup>70</sup> The subsequent expansion of Medicare benefits in the 1970's encouraged the growth of for-profit renal dialysis centers and home health agencies while similar expansions of investor owned psychiatric facilities resulted from other public financing.<sup>71</sup>

The expansion of investor-owned insurers increased competitive pressures on nonprofit insurance organizations. Commercial insurers offered policies based on the experience of particular groups rather than the overall health care use in the community. For groups with below average risk of illness, including many employee groups, this experience rating offered much lower premiums than did community rating. During the 1950's a

67. M. Schlesinger, *supra* note 28, at 79.

68. *Id.*

69. See Table 2.

70. See generally P. STARR, *supra* note 3, at 434 ("Expanding private insurance and Medicare gave the financial impetus to proprietary chains.").

71. See Table 2, *supra*.

number of employee groups shifted from the Blues to commercial carriers, and others threatened to do so. In the face of this competitive pressure, Blue Cross and Blue Shield virtually abandoned community rating by the 1960's, eliminating the implicit subsidy to high risk individuals.<sup>72</sup>

This was but the first example of a number of changes in the services offered by nonprofit health providers faced with competition from investor-owned institutions. The breadth and significance of these changes, however, became apparent only in combination with other changes in American medicine. The introduction of Medicare and Medicaid, together with the growth of private health insurance, sharply increased the flow of funds into the health industry and transformed medicine into a virtual gold-mine for commercial nonprofit as well as for-profit enterprises.<sup>73</sup>

Although third-party payment was a key transformative factor for American medicine, Blue Cross and Blue Shield, like hospitals, did little to threaten the autonomy of physicians. The benign nature of Medicare's early administration and the regularity of its payment reinforced the earlier patterns of third-party private insurers. The result was that, both before and after Medicare's passage, the power to determine medical costs still lay within the medical profession, whose interests continued to be furthered, though less directly, through Blue Cross.

Government health insurance prompted a period of extended growth for American medical institutions. Medicare permitted generous depreciation allowances for capital and, by reimbursing capital costs which were plowed back into the cost base, inserted an inflationary factor into its own payments, which were then determined by the provider-dominated insurers.<sup>74</sup> It was thus no surprise that the rate of hospital room charges increased at over twice the annual rate of the consumer price index.<sup>75</sup>

72. See J. KRIZAY & A. WILSON, *THE PATIENT AS CONSUMER* 40 (1974).

73. The relative position of Blue Cross also improved as a result of Medicare since organizational participants in the plan were permitted to adopt a "fiscal intermediary" rather than deal directly with the Social Security Administration. The majority of hospitals and other organizations chose Blue Cross. Similarly, the government had to choose insurance agencies and most of these were Blue Shield plans. See P. STARR, *supra* note 3, at 375. See also J. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* 37 (1977); S. LAW, *supra* note 43, at 31-41; T. MARMOR, *supra* note 56 at 141. This concession signified an accommodating disposition toward hospitals and physicians in Medicare's first years of operation. Moreover, Blue Cross' cost-based scheme of hospital reimbursement, transferred nearly intact to Medicare, meant that Blue Cross assumed a far more important position than when it was simply in the business of selling group hospitalization insurance. S. LAW, *supra* note 43, at 63-65, 93-102.

74. J. FEDER, *supra* note 73, at 113-17.

75. NATIONAL CENTER FOR HEALTH STATISTICS, *PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH AND PREVENTION PROFILE* 264 (1983) (pre-publication copy). See generally A. ENTHOVEN, *supra* note 15; Marmor, Wittman & Heagy, *The Politics of Medical Inflation*, in T. MARMOR, *POLITICAL ANALYSIS AND AMERICAN MEDICAL CARE* 61 (1983) [hereinafter cited as T. MARMOR, *POLITICAL ANALYSIS*].



High levels of medical inflation continued throughout the 1970's,<sup>76</sup> as reform efforts concentrated on new forms of health regulation and new methods of delivering care. Regulatory initiatives such as Professional Standards Review Organizations (PSROs) and Health System Agencies (HSAs) were begun with national health insurance in the minds of some reformers. National health insurance, however, never materialized, leaving the federal government and the health industry with fragmented controls. The inflationary forces at work in medicine—principally broad health insurance coverage, pluralistic financing, and weak countervailing regulatory authorities—worked their will throughout the 1970's. The decade began with marked medical inflation, witnessed hopeful initiatives along with frustrated public reform aimed at bringing access, cost, and humane health care into a reasonable equilibrium, and ended with a strong mandate for cost control in Washington.<sup>77</sup>

76. See Schlesinger & Blumenthal, *Ownership and Access to Health Care: New Evidence and Policy Implications*, NEW ENG. J. MED. (1986) (forthcoming).

77. The Federal Government encouraged the growth of pre-paid health plans by passing the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1974) (codified in scattered sections of 42 U.S.C.), which authorized a system of local health planning organizations or health systems agencies (HSAs), to be dominated by consumers, designed to cut the costs of medical care, guarantee quality, and improve access. The restraining effects of these HSAs, however, were modest. See Morone & Marmor, *Representing Consumer Interests: The Case of American Health Planning* in T. MARMOR, *POLITICAL ANALYSIS*, *supra* note 75, at 76; P. STARR, *supra* note 3, at 416.

Health maintenance organizations (HMOs) have become an alternative in many communities. Patients pay a flat annual sum and directly receive a wide array of medical services. The HMO must provide services within a fixed budget determined by the number of subscribers. See ANDERSON, HEROLD, BUTLER, KOHRMAN & MORRISON, *HMO DEVELOPMENT: PATTERNS AND PROSPECTS* (1985).

Further examples of efforts to control the cost of health care include the enactment of Certificate of Need (CON) programs which require state approval of construction and large capital programs planned by medical institutions. P. STARR, *supra* note 3, at 398. Other regulatory attempts to control medical costs included requirements for prior authorization, restrictions on capital expenditures, and reductions in the number of hospital beds. See Brown, *Public Hospitals on the Brink: Their Problems and Their Options*, 7 J. HEALTH POL. POL'Y & L. 927, 936-37 (1983). More recently, in the 1980's, the federal government has attempted to control costs by establishing Diagnostic Related Groups (DRGs) which establish price limitations on a variety of hospital services. See generally Morone & Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263 (1985) (a discussion of New Jersey's experience with DRGs). For a discussion of the potential ineffectiveness of restrictions on capital expenditures as a cost controlling mechanism, see Marmor, Wittman & Heagy, *The Politics of Medical Inflation* in T. MARMOR, *POLITICAL ANALYSIS*, *supra* note 75, at 61, 72. See generally Brown, *supra* note 20, at 23-24; A. ENTHOVEN, *supra* note 15 (discussing medical inflation); Marmor & Dunham, *The Politics of Health Policy Reform: Problems, Origins, Alternatives, and a Possible Prescription*, in CENTER FOR NATIONAL POLICY HEALTH CARE: HOW TO IMPROVE IT AND PAY FOR IT 34-35 (1985) (discussing fragmentary regulations of the 1970's); P. STARR, *supra* note 3, at 381-411, 436-39; Starr & Marmor, *The United States: A Social Forecast*, in THE END OF AN ILLUSION 234 (J. de Kervosdoué, J. Kimberly & V. Rodwin eds. 1984).

Professional Standards Review Organizations (PSROs) are an example of the effort to control the quality (as well as the cost) of medical care. They function:

by reviewing admissions to a health care facility, certifying the necessity for continuing treatment in an in-patient facility, reviewing other extended or costly treatment, conducting medical

C. *1975-1986: The Debate over Containment of Health Costs and the Growth of Price Competition*

By the 1970's policymakers and Americans generally were alarmed by the persistent growth of medical costs. This led directly to some changes in the health industry—the growth of prospective payment, the increased consolidation of insurance and service delivery within pre-paid health plans, and a variety of regulatory measures.<sup>78</sup> It has also had some indirect effects. These have included threats to the financial stability of government-operated health facilities and subtle shifts in popular expectations about the responsibility of health facilities to the communities in which they are located.

Perhaps the most important development is increased price competition among suppliers of medical services. This price competition has taken a number of forms. A variety of negotiated arrangements, including "preferred provider" and "exclusive provider" agreements, have been established to channel patients to a single or small group of providers in return for price discounts.<sup>79</sup> Third-party payers have negotiated more actively over prices, eroding the ability of hospitals to cross-subsidize particular types of care and patients.<sup>80</sup> HMOs, with historically lower rates of hospitalization and costs, have grown substantially, with enrollment increasing from less than six million in 1975 to over twelve million in 1983.<sup>81</sup>

evaluation studies, regularly reviewing facility, practitioner and health care service profiles of care and reviewing facility and practitioner records as applicable to a particular review process.

M. RAFFEL, *supra* note 20, at 282 (quoting DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, PSRO FACTBOOK 2-3 (1977)).

78. See *supra* note 77.

79. Rice, Lissovoy, Gabel & Ermann, *The State of PPOs: Results from a National Survey*, 4 HEALTH AFF. 25 (1985) (report on the status of Preferred Provider Organizations).

80. Sloan & Becker, *Cross-Subsidies and Payment for Hospital Care*, 8 J. HEALTH POL. POL'Y & L. 660, 677-78 (1984); Clark, *supra* note 11, at 1480-81.

81. This growth should be interpreted with caution. In simple terms, doubling market share in any industry from five to ten percent is easier than increasing that share from ten to twenty. HMO enrollment was quite low a decade ago, and the doubling of its clientele from that level need not foreshadow similar rates of growth on the now higher base. Secondly, what counts as a Health Maintenance Organization has, over time, been defined more loosely, now including, for example, groups of physicians coordinated under a pre-payment rubric of IPAs (individual practice associations). Thirdly, as HMOs have grown, they have increasingly come to be owned by other firms in the health industry such as Blue Cross, Blue Shield, commercial health insurance firms like Prudential, and, more recently, some for-profit hospital chains. These changes in corporate governance make the character of the HMO industry quite different from the model organization that the HMO Act of 1973 envisioned. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914.

Finally, it hardly needs pointing out that it is the financial incentives of pre-paid group practice, not the legal category of health maintenance organizations, that explain most of the cost-restraining effects associated in the literature with HMOs. Luft rightly cautions that most of the cost-saving effects arise from more restrained use of hospitalization, some of which in turn is explained by the healthier populations who joined the earlier groups. Luft, *How Do Health-Maintenance*

Increased competition in health care has significantly affected the role of private nonprofit providers. The decline of cross-subsidies of patients and services has reduced the ability of nonprofit institutions to offer unprofitable services, which had previously distinguished them from their for-profit counterparts.<sup>82</sup> On the other hand, the loss of cross-subsidies and the increased dumping of the sickest patients from private facilities has threatened the financial stability of many public institutions.<sup>83</sup> Between 1977 and 1983, 128 short-term hospitals operated by state and local governments were closed, a seven percent decline.<sup>84</sup> Ironically, the need for charity from private health institutions seems to be growing when nonprofit organizations are least willing to meet that need.

At the same time, there have been subtle shifts in popular expectations about the responsibilities of health providers. Patients in the past have relied significantly on a physician's competence and fiduciary responsibility. The basis for this trust seems to be eroding as the service ethic in health care has been demythologized and a more commercially oriented ethic has developed among providers. These changes have been accompanied by a loss of professional authority and autonomy. Some of the power once wielded by physicians has shifted to those who previously supported them—the financial and operating officers of hospitals, prepaid group practices, and both Blue Cross and Blue Shield.

Increased competition and decreased professional autonomy have reduced or eliminated some of the goals and practices which once distinguished nonprofit from for-profit providers of health care. Nonprofit institutions increasingly imitate their investor-owned competitors by establishing holding companies, for-profit subsidiaries, multi-facility chains, and by creating hierarchical structures which add to the role and discretion of non-physician managers.<sup>85</sup> As with the Blues in the late 1950's, there is arguably a convergence in practice between nonprofit and for-profit health care facilities. At the 1985 annual meeting of the American Psychiatric Association, for example, Dr. Eisenberg of Harvard Medical School observed that:

*Organizations Achieve Their "Savings"?*, 298 NEW ENG. J. MED. 1336, 1342 (1978). Over time, the rate of increase in HMO costs has paralleled medical inflation, thus suggesting that the effects of HMO growth on inflation control have been exaggerated. See L. BROWN, *POLITICS AND HEALTH CARE ORGANIZATION: HMOs AS FEDERAL POLICY* (1983); H. LUFT, *HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE* (1981).

82. See Schlesinger & Dorwart, *Ownership and Mental-Health Services*, 311 NEW ENG. J. MED. 959 (1984).

83. See Feder & Hadley, *The Economically Unattractive Patient: Who Cares?*, 61 BULL. N.Y. ACAD. MED. 68, 70 (1985).

84. AMERICAN HOSPITAL ASSOCIATION, *HOSPITAL STATISTICS* 7 (1983).

85. See *supra* text accompanying notes 4-14.

The worst of it is that voluntaries, unable to cross-subsidize expensive but essential clinical services because of cost-competition, are becoming ever less distinguishable from the proprietaries, as they 'market', and worse, 'demarket', diversify, 'unbundle', 'spin-off' for-profit subsidiaries, develop 'convenience-oriented feeder systems', attempt to adjust case mix, and triage admissions by their ability to pay.<sup>86</sup>

#### D. *Summary: Historical Lessons on the Role of Nonprofit Health Care Providers*

Our historical review of nonprofits in the health world suggests two important patterns. First, for each service, there appears to be a "life cycle" in the role of nonprofit providers. As new services develop, through technological or social innovation, the initial pioneers are almost always private nonprofit agencies. This is in part because new services tend to be expensive and require subsidies from public or philanthropic sources. Most likely, it also reflects the importance of nonpecuniary goals for the most innovative providers.

As a health service gains broader acceptance, however, two important changes occur. First, insurers become more willing to pay for treatment,

86. L. Eisenberg, *The Right to Health Care: For Patients or For-Profits* (paper presented at the annual meeting of the American Psychiatric Association, Dallas, TX, May 21, 1985) (a negative response to the debate resolution: "Investor Owned Medical Care is a Positive Move for the Field of Psychiatry"). See generally, Wessel, *Hospital Trustees' Role Grows Tougher as Financial and Charitable Goals Clash*, Wall St. J., March 18, 1986, at 31, col. 3 (discussing the "rising tensions between trustees' need to be prudent business managers and their desire to keep charitable programs alive.")

Perhaps the most vivid manifestation of this trend toward commercialization and the pressure toward more businesslike management can be found merely by leafing through the advertisements in a recent issue of the periodical entitled *Healthcare Financial Management*. Examples of excerpts from such ads include: "Now more than ever accounting for costs is an important and challenging responsibility. That's why Ernst & Whinney offers *Standard Cost Manager*. . . . This means you will be able to account for labor, material, and other line items in any department for improved decision making and control. . . ." HEALTHCARE FIN. MGMT., April, 1986, at 9; "In today's competitive marketplace, your hospital's image can significantly effect your ability to accomplish census objectives." *Id.* at 14; "In this tough, competitive, fast moving environment you need management tools that can improve your operational efficiency without reducing patient care service levels. That's where Touche Ross can help." *Id.* at 69; "Call Owen. We answer with a plan for improving your bottom line. By improving your pharmacy's operation, just as we have in 130 hospitals nationwide, Owen will streamline your operation and personnel. . . . And, most importantly, we'll control pharmacy costs. While safeguarding the highest standards in quality and patient care." *Id.* at 97.

This same magazine also carries a promotion for an upcoming conference sponsored by the Health Care Financial Management Educational Foundation entitled "Meeting the Challenge of Change." The titles of some of the seminars are particularly revealing. Examples include: "Marketing and the Role of the Chief Financial Officer"; "Acquisitions and Consolidations of Not-for-Profit Hospitals and Health Care Providers"; "Conversion of Tax-Exempt HMO's to For-Profit Status"; "Creating Competitive Advantage"; "Financial and Strategic Tools"; "Long-Term Care Business Opportunities for Growth and Profit"; "Fraud and Abuse in the Competitive Environment." *Id.* at 18-25.

and this increases the overall demand for the service.<sup>87</sup> If this increase is sufficiently rapid, existing nonprofit providers may not be able to meet the increased demand for the service. Under these conditions, patients and their physicians are forced to turn to proprietary agencies to obtain treatment. The resulting entry of for-profit institutions creates competitive pressures which tend to bring about a convergence between the behavior of both the nonprofit and for-profit providers. Second, policy makers become concerned with ensuring adequate access for those unable to pay for the service. This concern leads them to provide subsidies to public agencies to supply the poor and uninsured; this, in turn, tends to reduce the importance of charitable provision of care by private nonprofit agencies.

To understand the role of nonprofit medical care providers, it is thus important to know where a particular service lies in this life cycle. For the health sector as a whole, there will be some services at early stages, some at intermediate, and some at later stages. HMOs, for example, are just now moving from the first to the second stage; hospitals are now entering the last stage.

The second historical pattern indicates that the role of physicians varies for different types of health related services. The shift in the role of physicians can be seen generally in the relationship between the degree of physician authority over the delivery of care and the extent to which for-profit organizations supply a particular service. The health activities in which doctors play the least important role are precisely those where proprietary enterprises deliver the largest portion of services—health insurance, nursing homes, blood banks, and residences for the mentally impaired.<sup>88</sup>

Thus, there may be an important link between professional incentives and authority and the role of nonprofit medical facilities. What this relationship implies normatively has caused considerable debate. Some view physicians' authority in nonprofit agencies as essentially elitist, reflecting motives which diverge from other important social values.<sup>89</sup> Others argue that this authority furthers important social goals: access to care for the poor, avoidance of low quality care, and the strengthening of a fiduciary relationship between health institutions and the communities in which they are located.<sup>90</sup>

87. Most health insurance plans, for instance, do not cover the costs of "experimental" procedures. It is only when such care is provided on a sufficiently wide spread basis that it is covered and thus affordable for most individuals.

88. See Table 1 *supra*.

89. See, e.g., Clark, *supra* note 11, at 1439.

90. See, e.g., Relman, *supra* note 2, at 967-68.

### III. The Impact of Organizational Form on the Cost and Quality of Health Care Services and on Patient Access

To better understand the ways in which competition has led to a convergence in the practices of for-profit and nonprofit facilities, and the extent to which this has happened, it is useful to review the existing literature on the comparative performance of contemporary for-profit and nonprofit health care institutions. This review of the literature will also clarify the interaction of professional incentives and ownership. American health policy has concentrated on three primary aims: promoting access to care, limiting the cost of treatment, and assuring the provision of services of adequate quality.<sup>91</sup> Past studies of the effects of ownership on the behavior of providers have understandably focused on these same three areas.

#### A. Cost of Services

Over a dozen studies have compared average costs of care in nonprofit and for-profit nursing homes. Using varying sources of data and measures of costs, these studies have reached a common conclusion—controlling for characteristics of patients, range of services provided, and other attributes of the facility, for-profit homes have average costs five to fifteen percent lower than their nonprofit counterparts.<sup>92</sup>

In contrast, investigations of the hospital industry have found only small, inconsistent differences in reported costs of proprietary and nonprofit facilities. Cost per day is generally higher in for-profit facilities, but shorter lengths of stay have led to their relative cost per admission being measured as lower in some studies, higher in others, and roughly equal in the rest.<sup>93</sup>

91. See *supra* note 77.

92. Ten of the studies are reviewed and summarized in Bishop, *Nursing Home Cost Studies and Reimbursement Issues*, 2 HEALTH CARE FIN. REV. 47, 52 (1980). Since that review was published, additional research has been completed. See M. KOETTING, *NURSING HOME ORGANIZATION AND EFFICIENCY* (1980); Frech & Ginsburg, *The Cost of Nursing Home Care in the United States: Government Financing, Ownership, and Efficiency* in HEALTH, ECONOMICS, AND HEALTH ECONOMICS 67-81 (J. Van Der Gaag & M. Perlman eds. 1981); Caswell & Cleverley, *Cost Analysis of the Ohio Nursing Home Industry*, 18 HEALTH SERVICES RESEARCH 359 (1983); Schlenker & Shaughnessy, *Case Mix, Quality and Cost Relationships in Colorado Nursing Homes*, 6 HEALTH CARE FIN. REV. 61 (1984).

93. See Bays, *Cost Comparisons of For-Profit and Non-Profit Hospitals*, 13C SOC. SCI. MED. 219 (1979) (concluding "[F]orprofits in general are no less costly than nonprofits, but that chain forprofits are significantly less costly than are other types of hospitals"); Lewin, Derzon & Margulies, *Investor-Owned and Nonprofits Differ in Economic Performance*, HOSPITALS, July 1, 1981, at 52 (finding higher revenues per day and per stay but only slightly higher costs for investor owned hospitals as compared to not-for-profit, non-chain, community hospitals); Sloan & Becker, *supra* note 80, at 660 (finding that the overall savings in payments to hospitals is in the form of reduced profits, not reduced costs); Sloan & Vraciu, *Investor-Owned and Not-for-Profit Hospitals: Addressing Some*

This research indicates that there are ownership-related differences in costs in facilities such as nursing homes where physicians' roles are relatively attenuated,<sup>94</sup> but no difference in facilities such as hospitals where there is a stronger professional presence.<sup>95</sup> This suggests that professional standards and incentives mitigate some of the incentives for cost reduction (either through increased efficiency or reduced quality) which might otherwise be associated with for-profit ownership.

### B. *Quality of Services*

Assessments of ownership-related differences in quality, for the most part, mirror the findings on the costs of care. For those facilities in which physicians control the delivery of care, there seem to be few, if any, measurable differences in quality.<sup>96</sup> For example, a recent review concluded that at least under existing standards, there is no evidence that the profit motive induces physicians to compromise quality, "[u]nless new definitions of quality are proposed which are more rigorous, comprehensible, measurable, and widely acceptable than those noted above, there appears to be no basis for examining this dimension beyond the results of existing studies."<sup>97</sup>

On the other hand, where physicians play a less active role, there is, in fact, evidence suggesting that lower quality care is found in for-profit settings. Whether there are differences in the *average* quality is a matter of debate.<sup>98</sup> There is evidence, however, that for-profit facilities are disproportionately represented among institutions offering the very lowest quality care.<sup>99</sup>

*Issues*, 2 HEALTH AFF. 25, 34 (Florida study finding relative community costs of nonteaching not-for-profit and investor owned hospitals virtually identical and concluding "[O]wnership. . . is a poor predictor of a hospital's willingness to treat low-income patients, costs to the community, and profitability.").

94. M. KOETTING, *supra* note 92.

95. See Sloan & Becker, *supra* note 80.

96. See Schlesinger & Dorwart, *supra* note 82, at 959 (finding no simple correspondence between the form of ownership and quality of care, but rather, that effects of ownership vary with the types of services being provided); Schlesinger, *The Rise of Proprietary Health Care*, BUS. & HEALTH, Jan.-Feb. 1985, at 7, 11 ("where physicians play a more active role, the incentives produced by the profit motive may be largely mitigated by standards of professional behavior").

97. Sherman & Chilingirian, *For Profit vs. Non Profit Hospitals: The Effect of the Profit Motive on the Management of Operations* 4 (December, 1984) (unpublished manuscript on file with the *Yale Journal on Regulation*).

98. Studies comparing for-profit and nonprofit nursing homes have reached a variety of conclusions. See, e.g., M. KOETTING, *supra* note 92; Holmberg & Anderson, *Implications of Ownership for Nursing Home Care*, 6 MED. CARE 300 (1968); Riportella-Mueller & Slesinger, *The Relationship of Ownership and Size to Quality of Care in Wisconsin Nursing Homes*, 22 GERONTOLOGIST 429 (1982); S. Ullman, *Ownership and Performance in the Long-Term Health Care Industry* (Dept. of Economics Working Paper, University of Miami, January, 1983).

99. See D. SMITH, *LONG-TERM CARE IN TRANSITION: THE REGULATION OF NURSING HOMES* 86 (1981); B. VLADECK, *supra* note 37, at 123.

*C. Ownership and Access to Medical Care*

Throughout their history for-profit institutions have labored under the suspicion that they treat only the more profitable patients. In 1970 it was noted that "the most serious indictment of proprietary hospitals is contained in the argument that has been labeled 'cream-skimming'."<sup>100</sup> Sixteen years later the scale of proprietary operations has enlarged greatly, but the concerns of observers have not changed. The quest for profits is regarded as "an additional motive to private provider groups and institutions to engage in patient skimming and to discontinue needed but cost-ineffective services."<sup>101</sup>

Private nonprofit institutions, however, are also reported to select patients carefully. In the mid-1970's, the National Health and Environmental Law Project received a number of reports from local legal services programs indicating that there was significant channeling of "indigent patients who present themselves for treatment at private, not-for-profit hospital emergency rooms to municipal and county hospitals."<sup>102</sup> Based on these and other reports, some analysts have concluded that "cream-skimming" is a major factor within the voluntary sector as well: "The suburban community hospitals avoid the poor. . . The voluntary teaching hospitals prefer if they can to take the 'interesting cases' and send everyone else to the city or county hospital."<sup>103</sup>

It is clear then that both private nonprofit and commercial health providers engage in some screening of patients who seek care. If ownership affects restrictions on access, it will thus be reflected not in the presence, but in the nature or extent, of patient selection. Facilities may select among patients to further a variety of organizational objectives, including increased profits or enhanced status as teaching or research institutions. We focus here on selection of patients on the basis of profitability, since this can be most readily measured.

Health care providers can avoid unprofitable patients in three ways. First, facilities can simply be located away from low-income areas. Second, they can choose not to provide services disproportionately used by the uninsured or under-insured. Third, they can actively screen for and

100. Steinwald & Neuhauser, *supra* note 42, at 832. Critics argue that proprietary hospitals engage in two forms of "cream-skimming": those involving services and those involving patient selection. According to this view, they skimp on expensive and underutilized services and exclude patients with complex illnesses who are uninsured or covered by Medicaid and cannot pay their full charges.

101. Nutter, *Access to Care and the Evolution of Corporate, For-Profit Medicine*, 311 NEW ENG. J. MED. 917, 918 (1984).

102. Silver, *The Legal Accountability of Nonprofit Hospitals*, in REGULATING HEALTH FACILITIES CONSTRUCTION 183 (C. Havighurst ed. 1974).

103. Neuhauser, *The Future of Proprietaries in American Health Services*, in REGULATING HEALTH FACILITIES CONSTRUCTION 240 (C. Havighurst ed. 1974).



discourage admission of those unable to pay for care. This screening could be accomplished by requiring a means test prior to admission or by not offering sliding fee scales for patients unable to fully cover the costs of care. Evidence from past studies suggests that for-profit providers are more likely to use each of these methods, and that this occurs both for facilities in which physicians play an important role and for those in which they do not.

### 1. *Screening and the Location of the Facility*

To the extent that facilities avoid patients with limited ability to pay, one would expect them to locate in affluent areas. If for-profit providers are more sensitive to these incentives, they should provide a higher proportion of services in these areas than in less financially promising localities. Studies of the location patterns of short-term general hospitals have, in fact, found that the services provided under proprietary auspices are more sensitive to changes in demand linked to ability to pay,<sup>104</sup> changes in population levels,<sup>105</sup> and extensive insurance coverage.<sup>106</sup> These patterns persist whether one focuses on all for-profit hospitals or just those associated with multi-facility chains.<sup>107</sup> Studies of proprietary psychiatric hospitals and home health agencies also demonstrate greater sensitivity to regional differences in ability to pay on the part of for-profit institutions.<sup>108</sup>

### 2. *Screening and Selection of Services*

To screen out patients with limited ability to pay, a facility can be expected to avoid offering two types of services: (1) those services which are either not reimbursed or under-reimbursed by insurance plans; and (2), those services which are used disproportionately by patients who are uninsured or covered by Medicaid.

104. See Kushman & Nuckton, *Further Evidence on the Relative Performance of Proprietary and Nonprofit Hospitals*, 15 MED. CARE 189, 202 (1977).

105. *Id.* The increased demand for care outstrips the ability of nonprofit hospitals to expand and meet the heightened demand. Therefore, a ready market exists, at least for a short time, for a proprietary hospital. Steinwald & Neuhauser, *supra* note 42, at 828.

106. The market share of for-profit hospitals increases for both Medicare and commercial insurance, but Blue Cross has no impact. Bays, *Patterns of Hospital Growth*, 21 MED. CARE 850, 855 (1983).

107. Mullner & Hadley, *Interstate Variations in the Growth of Chain-Owned Proprietary Hospitals, 1973-1982*, 21 INQUIRY 144, 149 (1984).

108. The proportion of care provided by proprietary psychiatric hospitals is over three times as high in those states in which private insurers are required to cover psychiatric inpatient care as in the states in which there is no such mandate, and proprietary home health agencies are almost three times as prevalent in states with "generous" Medicaid programs as in states with lower Medicaid payments. Schlesinger & Blumenthal, *supra* note 76.

Surveys of psychiatric hospitals, for example, show that for-profit institutions are indeed four to five times less likely to offer unreimbursed or under-reimbursed services than are either their private nonprofit or public counterparts.<sup>109</sup>

Facilities that select patients according to their ability to pay also can be expected to avoid those services which are used disproportionately by the indigent. Low-income patients are likely to be either uninsured or covered by Medicaid, which in most states pays hospitals at a rate far lower than reimbursement from other insurers.<sup>110</sup> In short-term general hospitals—where data on service mix is most readily available—these patients disproportionately use outpatient services, substance abuse programs, and dental care.<sup>111</sup> Controlling for the size of the institution and characteristics of the surrounding community, private nonprofit hospitals are significantly more likely than for-profit institutions to adopt services used by indigent patients.<sup>112</sup> These differences in behavior diminish, however, in smaller communities where the hospital is the sole provider of such services.<sup>113</sup>

### 3. *Screening and Admissions Policies*

Facilities can use admissions policies in at least two ways to select patients on the basis of ability to pay. On the one hand they can employ exclusionary policies (requiring a means test) to screen out particular classes of payers, such as the uninsured or those covered by Medicaid. Conversely, by providing services at a reduced charge, facilities can encourage the patronage of lower-income patients. Facilities that seek more profitable patients can be expected to adopt the former policies and to avoid the latter.

Surveys of physicians reveal that investor-owned hospitals are two to four times as likely to adopt policies to “discourage admissions” of

109. See Schlesinger & Dorwart, *supra* note 82, at 964. Several types of services are included in this category. Emergency telephone and suicide prevention services are generally unreimbursed, since the client is often unidentified and cannot be billed. Home care and day care programs tend, for historical reasons, to be under-reimbursed by insurers as well. *Id.* at 963.

110. Thus hospitals use revenues from full paying patients to subsidize the Medicare and Medicaid patients. Even for-profit hospitals care for some Medicare/Medicaid patients. The number of Medicare/Medicaid patients is large enough to possess sufficient market power to force hospitals to accept a substantial discount on the cost of care. Sloan & Vraciu, *supra* note 93, at 33.

111. M. Schlesinger, *supra* note 28, at 249-50.

112. See Cromwell & Kanak, *The Effects of Prospective Reimbursement Programs on Hospital Adoption and Service Sharing*, 4 HEALTH CARE FIN. REV. 67, 79-81, 82 (1982) (service adoption was found to be correlated with various measures of size, regulatory status, and physician composition of the hospital itself and also was correlated with medical need, ability-to-pay, and the concentration of providers in the hospital market area); Schlesinger & Blumenthal, *supra* note 76.

113. Schlesinger & Blumenthal, *supra* note 76, at 12.

uninsured or Medicaid patients.<sup>114</sup> In contrast, a survey of long-term care facilities, including nursing homes, psychiatric hospitals, and institutions for the mentally handicapped, found that proprietary facilities were one-third to one-half as likely to offer services at reduced charge as were their nonprofit counterparts.<sup>115</sup> These findings suggest that investor-owned institutions are more likely to select patients on the basis of their ability to pay. For-profit facilities are also more likely to locate in areas with higher incomes and to avoid offering services used most by indigent patients. Finally, proprietary providers appear more likely to screen patients on insurance status and less likely to encourage the patronage of low-income patients by offering sliding fee scales.<sup>116</sup>

Like all health care institutions, for-profit facilities respond to prevailing financial incentives. If they differ from nonprofit providers in this respect, it is because they seem to respond more vigorously to those incentives. The existence of large numbers of inadequately insured or uninsured citizens in this country creates incentives for all health care institutions to screen patients on the basis of ability to pay. For-profit institutions are more likely to do so, but, as the data presented above reveal, private nonprofit facilities also restrict access far more than do public health care providers.

### IV. Implications for Public Policy

The contemporary expansion of investor-owned health facilities has provoked much controversy, but not many changes in public policy. This article, accordingly, has concentrated on assessing the controversy and sorting out the apparently ambiguous relation between ownership and important health considerations like access, quality, and cost. Reviewing the historical and contemporary performance of nonprofit and for-profit health institutions, we have substantiated two claims about ownership and valued outcomes in medicine. The first is that factors other than form of ownership explain much of what is significant about the patterns of American medicine. The second is that when the mediating factors are held constant, ownership does have a fairly consistent influence on the delivery of medical care. The behavior encouraged by both for-profit and

114. *Id.* at 14.

115. *Id.*

116. All of these findings should be interpreted with caution. First, most of the comparisons reported above do not control for many of the factors other than ownership that can affect institutional policies. Second, there is considerable variation in the behavior of health care organizations within any ownership category. Among investor-owned institutions, there may be many that discriminate less than the average nonprofit facility. Wise policy-makers will take this variation into account. Third, before reacting to access restrictions imposed by for-profit providers, policy-makers should understand the origins of those screening practices.

nonprofit ownership has, under various circumstances, served public goals. The entry of for-profit providers has made available services which otherwise would have been too limited to meet rapidly growing or shifting patterns of utilization. The nonprofit form has provided a medium for innovative delivery of services and has provided, and continues in many instances to provide, an important source of care for those without the means (or insurance) to finance care. These findings pose two questions for policy makers. First, how should policies best be designed to take into account ownership-related differences in performance? Second, how can the positive aspects of each form of ownership best be preserved amidst the ongoing changes in American medicine?

#### A. *Policy Interventions and the Life Cycle of Medical Services*

Many past public policies have been designed specifically to change the mix of nonprofit and for-profit health care providers. Some states have prohibited, or proposed prohibiting, investor-ownership of health care facilities.<sup>117</sup> During some administrations, the federal government has subsidized the expansion of nonprofit facilities.<sup>118</sup> During others, however, the federal government has sought to expand the role of investor ownership in health care.<sup>119</sup>

These past policies have had, at best, mixed success. Policies designed to limit the role of for-profit providers have been circumvented by disguised profit-taking in ostensibly nonprofit organizations.<sup>120</sup> At other times, these policies have so restricted the entry of new providers that they have led to serious shortages in the availability of services.<sup>121</sup> Conversely, policies

117. Past ownership-based interventions have often been crude and, as a result, have met with mixed success. For example, when California adopted a pre-paid system of care for its Medi-Cal enrollees, policy-makers were concerned that pre-payment would create incentives to cut quality of care. To mitigate these incentives, they required that all participating pre-paid plans be organized under nonprofit auspices, on the theory that this would prevent providers from having a monetary incentive to reduce quality. This strategy was circumvented by entrepreneurs who established a set of nonprofit dummy corporations which effectively funneled profits to subsidiaries, creating essentially the same incentives as if the plans had been organized as proprietary corporations. See Chavkin & Treseder, *California's Prepaid Health Plan Program: Can the Patient Be Saved?*, 28 HASTINGS L. J. 685 (1977) (reviewing the development of the prepaid health plan program in California). See also McNeil & Schenkler, *HMOs, Competition and Government*, 53 MILBANK MEMORIAL FUND Q. 195 (1975) (examining the impact of laws prohibiting for-profit HMOs on the spread of HMOs generally); NEW YORK STATE TEMPORARY COMMISSION ON LIVING COSTS AND THE ECONOMY, REPORT ON NURSING HOMES AND HEALTH RELATED FACILITIES 13 (1975) [hereinafter cited as NEW YORK STATE COMMISSION] (proposing policies to "gradually phase out proprietary nursing facilities in New York and to substitute voluntary nonprofit institutions.").

118. See Clark, *supra* note 11 (discussing the array of preferential policies subsidizing nonprofits).

119. See B. VLADECK, *supra* note 37, at 44.

120. See, e.g., Etzioni & Doty, *Profit in Not-for-Profit Corporations: The Example of Health Care*, 91 POL. SCI. Q. 433-53 (1976). See *supra* note 117.

121. See B. VLADECK, *supra* note 37, at 250.

which have encouraged the spread of for-profit agencies have been criticized as government promotion of "profiteering" at the expense of decent quality medical care.<sup>122</sup>

As a result of these apparent failings, the use of preferential subsidies and, more generally, ownership-based interventions has to some extent fallen out of favor in the 1980's. Yet our view is that the past interventions failed not because they were fundamentally ill-conceived but because they were inappropriately timed. The appropriate response is not to abandon ownership-related interventions but to take the development cycle of a service into account in their design and application.

In the initial stages of the development of a service, treatment is offered almost exclusively in nonprofit settings. Ownership-related policies are thus largely irrelevant, and, if adopted, will do little to affect the delivery of health care. In the middle stages of the life of a service, demand typically exceeds the expansion capacity of nonprofits. To prohibit or limit the entry of proprietary organizations at this stage would therefore seriously restrict the total availability of treatment, perhaps doing more to inhibit than to enhance access. Under these circumstances, policies that target additional incentives to for-profit facilities would seem the preferred approach.<sup>123</sup>

In the later stages of the evolution of a service, the aggregate level of demand for treatment stabilizes and competition among providers increases. At this stage, the ability of investor-owned organizations to attract capital more rapidly than nonprofits becomes important in promoting access to care. The increased competition with proprietary facilities, moreover, forces their nonprofit counterparts to restrict access. Under these conditions, policies designed to limit entry or expansion of proprietary facilities, while encouraging nonprofit agencies, may be preferable.<sup>124</sup>

122. See, e.g., NEW YORK STATE COMMISSION, *supra* note 117, at 7 ("The ultimate cause of the failure of the nursing home industry to provide proper care is the fact that the industry is dominated by profiteers who seek to generate only profit, not proper care.").

123. For this purpose, the greater responsiveness of for-profit providers to financial incentives can be an asset as well as a liability. From the mid-1950's through the mid-1970's, many policy initiatives sought to encourage the expansion of the health care system. As the history of Medicare's end-stage renal disease (ESRD) program illustrates, the investor-owned sector responded much more readily than its non-profit counterparts. B. VLADECK, *supra* note 37, at 250. The 1972 ESRD amendments to the Social Security Act were intended to assure unrestricted access to care for all those with renal failure. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, § 2991 (amending 42 U.S.C. § 426(d)-(g)). The for-profit sector reacted more rapidly to the economic opportunity created by this new entitlement, opening facilities in many communities that were disproportionately poor or populated by minorities—areas in which nonprofit providers had been unable or unwilling to operate. See Lowrie & Hampers, *Proprietary Dialysis and the End-Stage Renal Disease Program*, DIALYSIS & TRANSPLANT, Mar. 11, 1982, at 191-204. See generally, Plough, Salem, Schwartz, Weller & Ferguson, *Case Mix in End-Stage Renal Disease*, 310 NEW ENG. J. MED. 1432 (1984) (comparing case mix of hospital-based and free-standing facilities).

124. For a more complete discussion of adapting policy to this life-cycle, see Schlesinger, Marmor

B. *Preserving the Nonprofit Ethos in a Price-Competitive Health Care World*

Many factors other than organizational form have dominated and continue to dominate the structure of American medicine. Factors shaping the modern health care industry—who pays for health care and how, the organizational characteristics of payers and providers, the number and distribution of physicians and nurses within a given health care field, and the larger political and economic environment—all dwarf the changes in corporate form.

American medicine continues to be in considerable difficulty. Access to adequate care remains a serious problem.<sup>125</sup> Although figures vary considerably, one study suggests that about 35 million people or fifteen percent of the population are not covered by a health insurance plan.<sup>126</sup> The costs of care have inflated enormously over the past decade and a half, rising from approximately \$75 billion, or 7.6% of GNP, in 1970 to more than \$387 billion, or 10.6% of GNP, in 1984,<sup>127</sup> without commensurate improvements in quality or utilization. There is also widespread concern that rising insurance costs and the associated pressure for cost reduction further threaten the quality of care available to Americans.<sup>128</sup>

If one imagines removing all the recent developments in organizational form—the growth of chains and for-profit hospitals—the above critique would remain substantially intact. The continuing problems with access and costs point to the presence of fundamental, long-standing features of American medicine that only partially manifest themselves in the overheated debate about the proper legal form of organization. The main challenge for public policy is to address these fundamental problems facing health care. Ownership based policies alone will not solve these problems. An understanding of the historical role of commercialism and professionalism—traditionally associated with for-profit and nonprofit organizations respectively—can, however, aid policy-makers in their efforts to improve the cost and quality in and access to health care services.

& Smithey, *Nonprofit and For-Profit Medical Care: Shifting Roles and Implications for Health Policy*, J. HEALTH POL. POL'Y & L. (forthcoming 1986) (unpublished manuscript on file with the Yale Journal on Regulation.)

125. This is true despite the past growth of private insurance, Medicare, and Medicaid.

126. Munnell, *Ensuring Entitlement to Health Care Services*, 62 BULL. N.Y. ACAD. MED. 61 (1986).

127. J. Reuter, *Health Care Expenditures and Prices 2* (1985) (Congressional Research Service Major Issues Systems Brief).

128. See ARTHUR ANDERSEN & CO., *HEALTH CARE IN THE 1990S: TRENDS AND STRATEGIES 4* (1984).

1. *Understanding the Shift in the Character of American Medicine*

To understand the problems facing the health care industry today, it is important to be clear about the dramatic changes that have occurred in the industry over the past decade. We have witnessed a massive shift in the *character* of American medicine, not merely a shift in the dominant *form*. The growth of the for-profit chains, the competitive challenges to business-as-usual, and the consequent shifts in the behavior of nonprofits are missed if one concentrates on nonprofit market share alone. The infusion of new capital in medicine has promoted competitive behavior in the industry, further exacerbating and obscuring the very conditions that should be the central subject of debate, namely, cost, access, and quality of care. Whatever the history of the nonprofit in American medicine, the evidence of its performance, relatively speaking, supports neither side of the nonprofit or for-profit debate. Both the for-profit and nonprofit health care providers have been affected by the growing commercialism of the health care industry and the associated decline of physician autonomy over health care decisions.

It is important to avoid a misleading characterization of the changes in American medical care. Legal forms are often held to stand for other institutional features associated with, but not identical to, the nonprofit, profit, or governmental structure of ownership. What commentators have inaccurately labelled as the rise of profit-making firms in health in fact stands for a number of separate developments. It represents, in part, medical capitalism in the form of large-scale corporate investment in medicine, as with HCA and AHS.<sup>129</sup> It stands as well for a spirit of entrepreneurialism—to use one of the vulgarities—that denotes a newer orientation toward profit, innovation, marketing sensitivity and the like.<sup>130</sup> Finally, it stands for the scale and geographic reach of new hospital units—religious, profit-making, or nonprofit—that range over many sites (chains) and may, as with HCA, vertically integrate with drug suppliers, insurance firms, or hospital product firms.

The growing commercialism of American medicine has had a major impact on the role of the physician in health care. New entrepreneurs and professional managers are taking profits out of medical care, and doctors are losing control to these new decision makers. The problem is most noticeable in for-profit organizations, but nonprofit organizations have also been affected. Where competitive pressures are great, the behavior of

129. Goldsmith, *supra* note 4, at 5.

130. See *The New Entrepreneurialism in Health Care: 1984 Annual Health Conference, The New York Academy of Medicine*, 61 BULL. N.Y. ACAD. MED. 1 (1985) (examining the “entry of major corporate for-profit enterprise in the direct provision of personal health services”).

for-profit and nonprofit institutions often converges.<sup>131</sup> Given that doctors and other medical personnel have been making the functional equivalent of profits under the old regime, it is unclear whether total profits and costs will increase under the new regime.<sup>132</sup> Who will benefit, however, and who will be accountable to whom, will certainly change. Small entrepreneurs—particularly physicians—seem to be losing power to larger organized corporate institutions, ones exemplified by Humana and Hospital Corporation of America and, in part, by the new nonprofit systems. Some of the changes now occurring, particularly the vertical and horizontal integration of medical care facilities, are historically unprecedented in health. They can, however, be understood as a familiar stage in the development of Western capitalism, the displacement of smaller units by larger ones in the name of rationalization.<sup>133</sup>

The health care debate, therefore, should not be solely over profits or profit-making. It must concern the control of patients, profits, and professional privilege. The argument is not so much about organizational forms as it is about the incremental decline of a service ethos—more naked in one sector, more camouflaged in the other. The culture of American medicine, already entrepreneurial and commercial by international comparison, will probably grow more so.<sup>134</sup>

All one needs to add here are the memorable words of the executive director of American Medical International's St. Jude Hospital in New Orleans, whose comments are typical of the view that medicine is nothing but an ordinary market service. In explaining why hospitals are justified in getting tough with patients who cannot pay for care, Mr. John

131. To summarize our conclusions, there do not seem to be appreciable differences for most American patients in the care provided by for-profit and nonprofit hospitals. We are not saying no differences exist—indeed we document them—but we want rather to emphasize that the near-term effects of the loss of market share by nonprofit hospitals do not correspond to the dire predictions of the critics.

If one shifts the question slightly, however, our interpretation changes substantially. We do see significant differences in the forms of ownership and management for medical care entrepreneurs, who want to take profits out of medical care in the form of stock ownership (and are big winners), and for doctors, who have been profit makers all along but are losing control to new profit-takers.

132. Surely the potential for profit growth exists. As Evans notes about the for-profit testing lab, "[T]he strong stimulus to 'more' which is a consequence of for-profit motivation justifies serious concern. Unnecessary testing is pure waste of resources. But for-profit organization does not, cannot, recognize unnecessary testing as an intellectual concept. Sales are their own justification." R. EVANS, *supra* note 3, at 231.

133. As Morone has observed, "[f]or-profit chains scramble the traditional discourse over American health policy by pitting the principle of free enterprise against that of physician autonomy." Actually this tension has long been present in American health care, but it took large and powerful corporations to take up the profession's ideology with a vengeance. Morone, *The Unruly Rise of Medical Capitalism*, 15 HASTINGS CENTER REP. 28, 28-29 (1985).

134. For a discussion of the difficulties of comparison between the British and American health care systems see Marmor & Klein, *Cost vs. Care: America's Health Care Dilemma Wrongly Considered*, HEALTH MATRIX (Vol. 4, 1986 forthcoming).



McDaniel noted that “[g]rocery stores don’t have to provide food to the indigent.”<sup>135</sup> This casual remark is terribly revealing in its acceptance of this business-like aspect of health care. This acceptance reflects a guiltless dismissal of centuries of concern that the care of the sick imposes special obligations on both the givers of care and the community as a whole. Of equal concern is the behavior of the nonprofit institutions that carefully nurture reputations for community service while, at the same time, transferring costly cases to the local county hospitals. The relative triumph of commercialism and the long decline of professional authority mark a major shift in the character of American medicine, not particular forms within it.

## 2. *Preserving the Best of Commercialism and Professionalism*

The central place of nonprofits in American medicine had been, for some fifty years, largely unchallenged. The community hospital—nonprofit in form, local in roots, often religious in character, which permitted physicians to use its capital as they brought in patients—was ubiquitous, an American institution that by the 1950’s had the quality of the familiar, the taken-for-granted. As the problem of medical inflation became epidemic in the late 1960’s and 1970’s, that form, along with much else in American medicine, was increasingly criticized, challenged, and sometimes even ridiculed.

The typical challenge was to point out the gap between the mission of the nonprofit and its reality, the ever-increasing revenues it bargained for with insurance companies, governments, and patients with a zeal often associated with capitalist enterprise. For much of the post-war period, this critique was associated with the alternative of government regulation and, for some, with the dream of national health insurance. But by the end of the 1970’s, a wholly different alternative had emerged from this quite common diagnosis. It was that competition—first from health maintenance organizations, and then from the chains of profit-making hospitals—would right the wrongs of medicine. Increased competition, it was argued, would help us all, and the pressure of profit-seeking and the vaunted efficiencies of that for-profit model of corporate organization were widely touted.<sup>136</sup> This most recent change in the debate set the context for our discussion of the role of nonprofits in medicine.

The vices of the for-profits do not exonerate the nonprofits, although one could hardly tell from the high-minded preachiness of some in the

135. See Grady, *The Cruel Price of Cutting Medical Expenses*, DISCOVER, May, 1986, at 25, 40.

136. See generally Marmor, Boyer & Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003 (1981) (analysis of procompetitive reform alternatives).

nonprofit health world. Nor does the inflationary history of the nonprofit health institutions of the past two decades make the proprietary institutions necessarily an answer to the costliness of American medicine. There are limits to what can be said by distinguishing between organizational forms; the differences, while there, are simply not that great. There should be few limits, however, to the vigilance with which we examine the behavior of health institutions and apply the appropriate constraints to the vices of their organizational virtues. There may be some areas where the innovative, energetic pursuit of profit will, under the right rules, bring social gain. Drug production and laboratory medicine now operate under such rules, with ambiguous results.<sup>137</sup> More competition between providers will almost certainly bring increased sensitivity to patients (particularly well-insured ones) and the costs of their care. Whether that sensitivity will mean caring or coddling is uncertain. Whether the concern about costs will produce true efficiency gains is uncertain but possible.<sup>138</sup>

There are parallel considerations for the nonprofits in health. Will the patient screening that is now profitably practiced by hospital administrators be rejected by physicians and nurses who might be concerned with providing care for the needy? Will the nonprofit rationale—the commitment to caring for the sick, however financed—re-enter our debates in a way such that responsible action is fiscally rewarded or, at the very least, not penalized? Will physicians discover anew the advantages of the nonprofit form without our policy makers losing the distinction between professional autonomy that helps patients and fiscal independence that simply augments the incomes of physicians?<sup>139</sup> Will we, in short, recognize that health care has been, for very good reasons, a not-only-for-profit industry and that no amount of marketing hype will make vulnerable patients the wary consumers of Adam Smith's theoretical markets?

The challenge for public policy will be to discover rules of the medical game that constrain the vices of both rampant commercialism and complacent professionalism. The real uncertainty is whether our polity is capable of such sophistication.

### 3. *The Special Problem of Caring for the Poor*

Policy-makers should recognize that the screening practices of for-profit health care facilities, and to a lesser extent those of nonprofit facilities,

137. See R. EVANS, *supra* note 3, at 209-31.

138. See *id.* at 225-26 (arguing that competition could promote more efficient production and distribution but creates inefficiencies in drug prescription and utilization patterns).

139. See generally Majone, *Professionalism and Nonprofit Organizations*, 8 J. HEALTH POL. POL'Y & L. 639 (1984) (discussing why professionals prefer to work in nonprofit rather than for-profit or bureaucratic settings).

result in no small measure from overt public policy decisions and from the failure of American government to alleviate some major social problems. The growth of proprietary health care institutions highlights the lack of consensus about, or clear policy toward, what constitutes adequate access to health care for our citizens. Nor is there any agreement on the responsibility of health care providers either to individuals seeking care or to the community in which providers are located.<sup>140</sup>

Over time, the rise of proprietary institutions, and practices inspired by them, will lead to further discrimination against unprofitable patients.<sup>141</sup> As access to care becomes more problematic, policy-makers may feel compelled to consider broad public insurance programs that will guarantee adequate coverage and payment for all Americans. It would be perhaps a fitting irony if the spread of for-profit medicine created conditions that prompted massive new governmental interventions into the organization and financing of health care services. It would be a further irony if private nonprofit institutions, in responding to the competitive challenge of

140. Generally, both public and private hospitals have a duty to accept all patients who require emergency care. See, e.g., *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 174 A.2d 135 (1961) (private hospital must provide emergency services to critically ill infant); *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329 (1983) (duty to treat in emergency situations). See generally *Recent Developments—Private Hospital Must Admit Unmistakable Emergency Cases*, 14 STAN. L. REV. 910 (1962); Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. LEGAL MED. 157 (1985); Annot. 35 A.L.R. 3d 841 (1971 & Supp. 1985) ("Liability of Hospital for Refusal to Admit or Treat Patient"). That duty, however, does not extend to the non-emergency situations, where the private hospital has no such obligation. See *Baltimore Co. Hosp. Inc. v. Maryland Hosp. Serv. Inc.*, 234 Md. 427, 200 A.2d 39, 41 (1964) ("A private hospital is not under a common law duty to serve everyone who applies for treatment. . . In the absence of statute, it may accept some applicants and reject others."). But see Marsh, *supra*, at 162 (suggesting that some confusion surrounds the question of the difference between duty to treat an emergency room patient and the obligation to admit that same patient for further treatment).

141. Under the new prospective payment systems such as Medicare's DRGs, all hospitals have the clear incentive to "specialize" in the care of low-cost, uncomplicated patients. Screening on the basis of cost will almost certainly increase in all types of facilities. Here too, however, investor-owned facilities seem likely to respond to these economic incentives more vigorously than will other providers.

In addition, the increased sensitivity of for-profit, and even nonprofit institutions, to the economics of health care services may threaten the viability of government-owned health care facilities. See generally Brown, *supra* note 77 (defining the differences among public community hospitals, and examining the problems faced by those that serve primarily the poor); Lewin & Lewin, *Health Care for the Uninsured*, BUS. & HEALTH, Sept. 1984, at 9 (public and private sector options for paying for the health care of the poor). In the hospital sector, for example, private providers will find it profitable to avoid costly patients within any particular DRG category. The propensity of for-profit facilities to locate in areas where relatively few unprofitable patients live and to screen such patients further through selective provision of services and exclusionary admissions policies will, at a minimum, increase the channelling of those patients to government-operated facilities. Brown, *supra*; Feder, Hadley & Mullner, *supra* note 61, at 544-66. For any particular DRG, costs in public institutions will grow over time, creating the impression that they are becoming less and less efficient relative to the private sector. This will undoubtedly lead to pressures to close more public hospitals, further exacerbating restrictions on access. Local, state, and federal governments must act to protect the financial stability of these facilities which, in many areas, insure a minimum level of access to health care. To the extent that public institutions are unable to meet new demands placed on them, some illness will go untreated.

proprietary chains, helped create these very same conditions on a scale much larger than the proprietary sector alone could produce.

### Conclusion

The adjustment of health policy to shifts in ownership is not new. Past interventions, however, have typically developed on an *ad hoc* basis without adequate assessment of their influence on the delivery of services.<sup>142</sup> We believe that this review of both the history and contemporary performance of nonprofit and for-profit health care facilities provides a basis for a more reasonable set of health policies.

Exorcising one form of ownership would neither eliminate nor render catastrophically large existing policy problems, such as ensuring the availability of health services at reasonable cost and quality.<sup>143</sup> While shifts in ownership are clearly neither the source of nor the solution to current failings of American medical care, the observed differences between nonprofit and for-profit performance are nonetheless relevant to health policy. When health care costs \$400 billion annually, the possibility of cutting costs by even ten percent through shifting services to the most efficient providers seems quite attractive. In a system in which a large portion of consumers remain abysmally uninformed about their options for treatment and the quality of the care they receive, however, the threat of cutting quality in the pursuit of providers' self-interest is a real and important concern.

The contemporary growth of investor-owned health care facilities has been viewed by proponents as the elixir for all that ails American medicine. Opponents see it as indicative of the virtual abandonment of a set of cherished social institutions and values. Both sides view the recent growth of the for-profit sector as foreshadowing a system-wide transformation, and perhaps complete conversion to proprietary auspices, of the health industry. In fact, it seems quite unlikely that such radical changes will occur. As we have seen, there have historically been a number of pronounced shifts in the relative importance of nonprofit and for-profit health care providers. These will continue to occur in the future, in response to changes in private wants, public subsidies, the changing authority of medical professionals, and the introduction of new technologies and services.

Policy-makers should shift their attention from an undue preoccupation with organizational form to take into account the massive changes in the

142. M. Schlesinger, *supra* note 28, at 350-74.

143. To use these differences to further social ends, however, requires a fairly sophisticated and complicated set of policies. See *supra* note 117.

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character of American medicine. The rise of commercialism and the decline of the professional ethos are developments that cut across organizational forms and raise fundamental questions about the relative importance of cost, quality and access in American medicine which health care policy must address.

